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ABSTRACT

This paper summarizes the process of instituting a standardized mental health assessment protocol in a community health treatment program serving maltreated youth. The assessment program was intended to: (1) provide descriptive data regarding the populating utilizing the service; (2) examine the efficacy of therapeutic interventions and monitor program quality; and (3) supply individual clinical data to mental health providers for use in treatment planning and monitoring. Data for 242 subjects receiving outpatient services for sexual, physical, or emotional abuse and neglect have been collected. Analysis is in terms of the three program goals. Concerning the goal of providing descriptive data, although assessments were conducted on only 60 percent of patients, data have been collected on demographics, maltreatment history, mental health service use history, and treatment expectancies, and mental health and family problems and competencies. Concerning use for assessing therapeutic efficacy, follow-up data have been collected for only 59 youth and their families. Concerning supplying individual clinical data to mental health providers, clinicians have reported satisfaction with assessment summaries. (Contains 16 references.) (DB)

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Introduction Method Results Discussion References

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Introduction

Although there are many research studies evaluating the efficacy of various mental health interventions for children and families, there are very few reports of ongoing standardized evaluation of treatment outcomes in community mental health services (Weisz & Weiss, 1989; Weisz, Weiss, & Donenberg, 1992). It is becoming increasingly important that outcome assessment be both widely applied and linked to data on patient characteristics and service utilization (Sederer, Hermann, & Dickey, 1995). Community mental health services are experiencing increased internal and external pressure to document the efficacy of their interventions and the effectiveness of the service system. These pressures have intensified in this era of managed care and diminished resources for mental health services. Furthermore, these pressures dictate that procedures be utilized which are both time and cost efficient (Kurkland, 1995). Unfortunately, increased pressure to evaluate outcomes has not necessarily coincided with the development of well established guidelines for implementing outcomes evaluation. Service settings are left with the difficult task of designing their own protocols, with or without consultation from researchers who have the necessary expertise in measurement and analysis.

The purpose of this study was to describe the process of instituting a standardized mental health assessment protocol in a community mental health treatment program serving maltreated youth. The protocol was specifically not implemented as a research project, but rather as a low cost component of standard clinical practice at the clinic. The goals of this assessment program were to:

- Provide descriptive data regarding the population utilizing the service, and describe individual and group differences in this population
- Examine the efficacy of therapeutic interventions and

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provide a mechanism for monitoring quality assurance
- Supply individual clinical data to mental health providers for use in treatment planning and monitoring.

Method

Service Site and Sample

Children's Hospital Center for Child Protection (CCP) Mental Health Treatment Program

The CCP mental health treatment program is an outpatient therapy program specifically for children and adolescents who have experienced maltreatment in the form of sexual, physical, or emotional abuse, or neglect. The majority of patients are referred for sexual abuse. Individual, group, and family treatment are available from an interdisciplinary team of psychologists, social workers, counselors, and trainees. In the fiscal year 1994, the program served more than 250 children and their parents. A standardized assessment protocol was introduced in mid 1994 and data for 242 subjects have been collected.

Description of Sample

Sixty-two percent of the subjects are female; the mean age was 8.7 years (SD = 4.0; range = 2-19). Approximately half of the sample was Caucasian (47%); African Americans and Hispanics composed 20% each of the sample, with the remainder classified as "Other." The majority of the families (61%) had total gross incomes of less than $20,000. Approximately two thirds of the children were referred primarily because of sexual abuse. Six-month follow-up data has been more difficult to obtain, but is currently available for 59 families.

Measures

Table 1, below, presents the measures selected for the assessment program, by domain of assessment and informant.

Issues which were addressed in the selection of instruments included:

- Goals and objectives of intervention (i.e. relevance of measure)
- Psychometric properties of instruments for the population being served (e.g., SES, race/ethnicity, culture, age, etc.), and
- Pragmatic issues, such as time of administration, costs, personnel, and training required.

Procedure

Assessment measures were administered by graduate

Assessment measures were administered by graduate students and research assistants who received training in the administration of the standardized instruments and some limited clinical interviewing skills. Families were scheduled for an intake assessment prior to initiating treatment. Data regarding the assessment were used to assign families to specific types of treatment and providers. A summary of the assessment data was provided to the clinician prior to the family's first visit. Follow-up interviews were scheduled six months after the intake assessment and the same battery of instruments was repeated.

Results

Results are presented and discussed based on the relative success of achieving the program goals and the obstacles confronted within the process.

Goal #1: Provide descriptive data regarding the population utilizing the services.

A great deal of descriptive data has been collected on the 242 youth assessed upon entering the mental health treatment program. Such data includes demographics, maltreatment history, mental health service use history, treatment expectancies, and standardized data regarding mental health and family problems and competencies.

There are, however, limitations in the usefulness of these data; variability in the clinical staff's comfort and familiarity with the instruments jeopardizes the reliability of results. Also, the data may not be representative of all youth and their families utilizing the service due to the difficulty involved in successfully assessing all children and their parents prior to treatment (Boren et al., 1996). Only approximately 60% of those who began treatment were assessed. Anecdotal data suggests that the reasons for missing the intake assessment include, crisis intervention implemented prior to assessment, scheduling difficulties, and language differences.

Goal #2: Examine the efficacy of the therapeutic interventions and provide a mechanism for quality assurance

The utility of the assessment program for evaluating outcomes obviously relies on the ability to collect follow-up data, as well as on the representative coverage of the assessments, as discussed above. To date, follow-up data have been collected for only 59 youth and their families, too few to provide a meaningful assessment of treatment outcomes. Uncertainty regarding whether a true cross-section of the patients is being considered in outcome evaluation may arise due to a lack of full participation in follow-up interviews. This is largely the result of difficulty in tracking some families after their initial interview.

A number of additional obstacles to obtaining reliable

A number of additional obstacles to obtaining reliable follow-up data are worth addressing. One such obstacle, related to clinicians' variable familiarity with the instruments, is the potential for variable commitment of the treatment program staff to standardized assessment. The requirements, for example, of standardization may run counter to the intentions of many clinical providers to adapt to the diverse, idiosyncratic, and changing needs of consumers, thereby seeming incongruent or even contradictory to the clinical and/or administrative procedures of a mental health treatment program. Indeed, lack of consistent commitment could impact the scheduling of intake interviews and follow-ups, further compromising the universality of outcome data collection.

Due to their integral role in the success of such an assessment protocol, clinicians must be highly involved in a collaborative implementation of it. The researchers introducing the procedure must emphasize their role as consultants, and must transfer administrative functions to the clinic in a timely manner. Training and data analysis can remain the researchers' responsibility; however, it is imperative to involve clinicians early in order to establish it as a standard clinical practice, rather than a research project. This entails getting input from clinical staff regarding research questions and constructs to measure prior to the protocol's implementation.

This assessment program was intentionally implemented as an integral component of ongoing clinical practice, as opposed to a discrete research project. Thus, there was no attempt to implement an experimental research design with random assignment to treatment conditions, etc. While this approach offered clinical advantages, there are limitations in the interpretations of results due to the lack of standardized conditions.

Goal #3: Supply individual clinical data to mental health providers for use in treatment planning and monitoring

Clinicians have reported satisfaction with the assessment summaries, although the treatment program manager reports that the summaries are not frequently used for assignment to treatment. Thus, possible variability in clinical utility is an issue of which to be aware.

Changes in the data reporting methods have been instituted due primarily to reimbursement issues. Reimbursement issues arose because the assessment protocol did not match the categories allowed for reimbursable expenses in many public and privately funded managed care programs. The procedures were therefore changed, and made more costly, so that the requirements for reimbursement could be met. Instead of an assessment summary completed by a paraprofessional, a full psychological evaluation report was produced by a licensed clinical psychologist, and the assessment was billed as psychological testing. This change, in some respects, was contrary to the initial purpose of the

in some respects, was contrary to the initial purpose of the protocol, which was to provide a low cost assessment program in the implementation of such a protocol.

Discussion

It is feasible to implement a standardized assessment protocol at relatively low cost in a community mental health treatment program. There are, however, several obstacles that need to be addressed including, lack of full coverage, reimbursement requirements, and tracking of families for follow-up. The introduction of standardized assessment to a treatment program requires the following:

- Early involvement and training of staff;
- Planning for fiscal impact and flexibility in reimbursement plan;
- The selection of feasible measures (e.g., time, cost, and training efficient), the data from which will meet the goals of the intervention;
- Well developed database and client tracking systems;
- Linkage of assessment data to service use data; and
- Timeline of implementation and plans for transition from trial to standard clinical practice.

With these issues addressed, a successful standardized assessment protocol can be implemented with benefits to clinicians, administrators, and researchers alike.

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